

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155376</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R-C</b> <b>12/04/2014</b>	
NAME OF PROVIDER OR SUPPLIER  <b>SHERIDAN REHABILITATION AND HEALTHCARE CENTER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>803 S HAMILTON ST</b> <b>SHERIDAN, IN 46069</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on September 30, 2014. This visit included the PSR to the investigation of complaint IN00155737. This visit was in conjunction with Complaint IN00160043.</p> <p>Complaint IN00155737: corrected</p> <p>Survey dates: December 2, 3 and 4, 2014.</p> <p>Facility number: 000336 Provider number: 155376 AIM number: 100290170</p> <p>Survey team: Gloria Bond, R.N., Team Coordinator Michelle Hosteter, R.N.(December 3, 4, 2014) Sandra Nolder, R.N.</p> <p>Census bed type: SNF/NF: 66 Total: 66</p> <p>Census payor type Medicare: 8 Medicaid: 44 Other: 14 Total: 66</p> <p>Sheridan Rehabilitation and Healthcare Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regards to the PSR to the Recertification and State Licensure Survey.</p> <p>Quality Review was completed by Tammy Alley</p>			{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 000}	Continued From page 1 RN on December 8, 2014.	{F 000}			